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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2017 FORM APPROVED

STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	DATE SURVEY
	•			3 <u></u>	COMPLETED
MANEGE	PROVIDER OR SUPPLIER	445246	B. WING _		01/31/2017
	SON CITY HEALTH AN	ND REHAB CENTER	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760	0170112017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
F 000	INITIAL COMMENT	rs	F 000	This Plan of Correction is the Center's credible allegation of compliance.	
F 205 SS=D	1/29/17 through 1/3 and Rehab Center, related to complaint Requirements for Li	2) NOTICE OF BED-HOLD	F 205	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or far alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed sole because the provisions of Federal and State law require it.	ely
	(1) Notice before tra- transfers a resident goes on therapeutic must provide written resident representat (i) The duration of th any, during which th return and resume re facility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facil bed-hold periods, wh paragraph (c)(5) of t resident to return; ar (iv) The information of this section. (2) Bed-hold notice u	payment policy in the state of this chapter, if any; ity's policies regarding nich must be consistent with his section, permitting a nd specified in paragraph (c)(3)		Resident 86 returned to the facility 12/24/16. Resident 103 no longer resides in the facility. Audit of each nurse's station was completed to validate bed hold police forms were available. Re-education regarding facility bed hold policy and providing copies to resident/responsible party who go to the hospital or on therapeutic leave began on 2/1/17. This was completed by the staff development coordinator by 2/09/17 for all nurses PRN staff and staff on leave will receive education prior to working. Audits will be completed by the assistant director of nursing to validate that copies of bed hold noti	D
	transfer of a resident therapeutic leave, a to the resident and the	t for hospitalization or nursing facility must provide ne resident representative		upon transfer are provided for hospitalizations/therapeutic leaves.	
BORATORY		RISUPPLIER REPRESENTATIVE'S SIGNA		3/8/17	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that desafeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days to swing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

12:01:46 p.m. 03-09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2017 FORM APPROVED OMB NO. 0938-0301

STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	LE CONSTRUCTION		0938-0391
	o contraction	IDENTIFICATION NUMBER:	A. BUILL			CON	E SURVEY IPLETED
	· ·	445246	B. WING	ŧ	<u> </u>		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	31/2017
JEFFER:	SON CITY HEALTH AN			2	83 W BROADWAY BLVD EFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
F 205	written notice which bed-hold policy desiths section. This REQUIREMENT by: Based on review of Packet, medical red facility failed to issue the resident and residents transfer, and dischareviewed. The findings include Review of the facility "Notice of Bed-Ho transferred out of the	specifies the duration of the cribed in paragraph (e)(1) of IT is not met as evidenced the facility's Admission ord review, and interview, the e a written bed-hold policy to ponsible party for 2 (#86 and reviewed for admission, rge rights of 32 residents d: 's admission packet revealed Id Policy-If you are e center to the hospital or	F2	205	Audits will be completed wee 4 weeks and then monthly. A will continue until substantial compliance is achieved as dete by QAPI. Audit results will be reviewed du QAPI meetings with revisions to plan as deemed appropriate by QAPI Committee.	udits rmined uring	
The state of the s	choose an overnight provide written inform policy to you. What is certain circumstance or verbal request for 'hold' a bed for the re'hold' a bed for the facilion 12/24/16 with dia Neoplasm of the Thy Respiratory Failure, Medical record revie transferred to the honausea, vomiting, ar Medical record revie a written bed-hold po	therapeutic leave, we will matton about our bed hold his means is that under as, including receipt of written a bed hold, the center will esident to be re-admitted" w revealed Resident #86 was by on 8/28/15 and readmitted gnoses including Malignant wrold Gland, Acute and Anxiety Disorder. w revealed Resident #86 was spital on 12/21/16 due to addifficulty breathing. w revealed no documentation blicy was provided to the ble party at the time of				Approximation of the state of t	

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			·	OMB NO	0. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
				J			WITE I GU
NAME OF	PROVIDER OR SUPPLIER	445246	B. WING	<u>-</u>		n ₁	/31/2017
		,	<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODE	_ , ,	10 1/20 1/
JEFFER	SON CITY HEALTH AT	ND REHAB CENTER			283 W BROADWAY BLVD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10		JEFFERSON CITY, TN 37760 PROVIDER'S PLAN OF CORRECT		
PŘĚFIX TAG	I (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI		(X5) COMPLETION DATE
					DEFICIENCY)	OI NAME	
F 205	Continued From pa	ge 2	F:	205	3		
	Medical record revi	ew revealed Resident #103					
	was admitted to the	facility on 11/3/16 with					
	diagnoses including Mellitus with Diabet	Cerebral Infarction, Diabetes ic Nephropathy, and					
	Dementia.	to reprinopality, and					
	Medical report route	ew revealed Resident #103					
	was transferred to t	he hospital on 11/16/16 for			·		
	evaluation.						•
[Medical record revie	ew revealed no documentation			1		
	l a written bed-hold b	Olicy was provided to the					'
	transfer to the hospi	ble party at the time of ital.				•	
	Interview with the As 1/31/17 at 9:02 AM.	ssistant Director of Nursing on in the lobby, confirmed the					i
	residents were not p	provided a conv of the facility's			1		
	transferred to the ho	N the residents were			·		
							1
	(BOM) on 1/31/17 a	Isiness Office Manager t 9:40 AM, In the lobby,	-				
	revealed the BOM M	as responsible to notify		·			
	namily members/resi	Donsible parties of the					
ľ	transferred to the ho	licy when residents were spital. Continued interview					[
	committed a Muttell I	lon sew soliton bion-DSC		ĺ		•	
	responsible party at	y members or the resident's the time the residents were					
F 500	uischarged to the ho	spital.					
F 223	483.12 FREE FROM SECLUSION	ABUSE/INVOLUNTARY	F2	23			
55-0							
	483.12 The resident has the						
	neglect, misappropri	right to be free from abuse, ation of resident property,		į		J	
<u> </u>				ĺ			
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Event ID: CWUS11

Facility ID: TN4691

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(X4) ID PREFIX

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5/30

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	02/13	1/2017
FORM	APPR	OVED
OMB NO	0020	0004

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

F223

1D

PREFIX

TAG

F 223

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

445246 B. WING

01/31/2017

(X5) COMPLETION

DATE

2/06/17

JEFFERSON CITY HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760

F 223 Continued From page 3
and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.

This REQUIREMENT is not met as evidenced by:

Based on facility policy review, medical reserving

Based on facility policy review, medical record review, review of employee files, review of facility investigation, and interview, the facility failed to prevent abuse of 1 resident (#139) of 32 residents reviewed. Resident #139 felt humiliated and suffered psychological harm.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

The findings included:

Review of the facility policies, "Preventing Resident Abuse" and "Reporting Abuse to Facility Management", revised on 11/28/16, revealed "...Our facility will not condone any form of resident abuse...verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...Mental abuse is defined as, but is not limited to, humiliation, harassment.."

Medical record review revealed Resident #139 was admitted to the facility on 4/4/16 with diagnoses including Acute on Chronic Respiratory Failure with Tracheostomy, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.

Review of the employee file for the Central Supply Clerk (CSC) revealed the employee was also a Certified Nursing Assistant (CNA). Review revealed on 11/2/16, "... Employee was angry while in the dining room serving residents lunch and was heard using inappropriate language and

Resident 139 was interviewed by Social Worker on 1/29/17. She remains at her baseline for facility milieu involvement, psychosocial and emotional well-being.

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Aide identified no longer works for facility as of 2/1/17.

Other residents interviewed by social services on 2/2/17 to determine if they had been spoken to in a disrespectful way. No other reports of inappropriate conversation or unprofessional conduct were identified per interviews. Education of staff began on 2/1/17. Sr Regional Clinical Coordinator provided training to administrator and director of nursing on 2/1/17. The policy for preventing resident abuse was reviewed by the administrator on 2/1/17 and deemed to be appropriate. Administrator reeducated all leadership staff in relation to abuse prohibition including definitions, reporting requirements, and provision of measures to ensure safety and protection of the resident(s). This was completed by 2/3/17.

Mandatory in-service education was scheduled for facility staff across all departments for abuse prohibition including definitions, reporting requirements, and provision of safety

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: CWUS11

Facility ID: TN4501

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DEPARTMENT OF HEALTH AND LUMAN DEDVI

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			_	FORM	APPROVED
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPL	LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER		<u></u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.14	31/2017
JEFFER:	SON CITY HEALTH A	<u>. </u>		2	183 W BROADWAY BLVD IEFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE I	(X5) COMPLETION DATE
F 223	cussing in front of redisruptive and distraresidents were eating. Medical record review (MDS) dated 1/6/17 cognitively intact with of 15 on the Brief in (BIMS). Review of a statement the Director of Nursidents with Edinary pertaining to a 1/27/17, revealed " loud and rude 'made interview with Licenton 1/30/17 at 3:45 Fon 1/27/17 Resident corner in her wheek interview revealed the dining room related interview with LPN the conference room [DON] before leaving Friday [1/27/17] to stabout the incident in with [DON] that [Resident in the conference room [DON] saidshe had interview with Resident interview with Residen	esidentsbehavior was very acting in the dining room while ng" ew of the Minimum Data Set revealed the resident was the the highest possible score atterview for Mental Status ent dated 1/29/17, obtained by sing (DON) from Resident an allegation of abuse on[CSC] jumped on herwas de me feel humiliated'" sed Practical Nurse (LPN) #1 PM, on the 600 hall, revealed t #139 "came around the chair crying." Continued the CSC had yelled at her in sted to the resident's oxygen, two [tanks of] oxygen" #1 on 1/30/17 at 5:10 PM, in n, revealed "I spoke with g my shift, about 2:15 PM, on see what was being done the dining roomtalked over sident #139] was yelled at d started an investigation."	F 2	223	records were audited against st listings to ensure all staff receive education. PRN staff and staff cleave will receive education price working. This education was provided wiface-to-face opportunity for staff ask questions and validate understanding of facility policies regulatory requirements. This education was completed by 2/6/17 to review abuse prohil and discuss need for residents to immediately report inappropriate conversation or any action that indicate a resident is being abuse. To validate compliance, the staff development coordinator or soc worker will interview five staff members and five residents weef or four weeks. Non-interviewable residents will be observed by nuduring medication administration routine nursing care for changes may indicate abuse. If no issues identified the facility will interview	aff red on or to th f to s and 06/17. s held bition to e might sed. f ial ekly ble urses n and s that s are wone	
{	PM, in her room, rev	realed the resident had been			staff member and one resident v	veekiy	

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in the main dining room for lunch on Friday,

1/27/17, when she "...ran out of oxygen...have to have my oxygen...asked for my oxygen tank to be

replaced, but [CSC] said she couldn't get it right

away...3 times I asked her to get me a tank and

Event ID; CWUS11

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for eight weeks to ensure unreported

abuse has not occurred and that staff

knowledge and understanding of the

members can demonstrate

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A SUIDNG SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD	STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY
JEFFERSON CITY HEALTH AND REHAB CENTER (X4) ID PRETX TAG (X4) ID PRETX TAG (X5) ID PRETX TAG (X6) ID PRETX TAG (X7) ID PROVIDER'S PLAN OF CORRECTION (X7) ID PRETX TAG (X7) ID PRETX TAG (X6) ID PRETX TAG (X7) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PRETX TAG (X6) ID PRETX TAG (X6) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PRETX TAG (X6) ID PRETX TAG (X6) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PRETX TAG (X6) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PRETX TAG (X6) I		-					COM	IPLETED
JEFFERSON CITY HEALTH AND REHAB CENTER (X4) ID PREFIX TAGGE (EACH DEFICIENCY MUST BE PRECEIVED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 5 she wouldn't, then [CNA #4] went out the door to get me a tank" Interview continued as the resident began to cry. Further interview revealed "she [CSC] yelled at me and told me I wasn't supposed to have 2 oxygen tanksI was so upsetI couldn't sleep all night" Interview with the Activities Assistant (AA) on 1/31/17 at 12:25 PM, in the conference of National Property of National Property Interview continued, "[Resident #139] came up to me crying on Friday [1/27/17] and explained to me what happened. I loid her to report it immediately to [Staff Development Coordinator (RN #3)] and [Assistant Director of Nurses]. [Resident #139] comes to a lot of activities and she normally is not upset and it knew she was really upset that day [1/27/17]." Interview with CNA#4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139 Interview with CNA#4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139 Interview with CNA#4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139 Interview with CNA#4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139	NAME OF I	PROVIDER OR SUPPLIER	445246	B. WING			01/	<u>31/</u> 2017
F 223 Continued From page 5 she wouldn't, then [CNA #4] went out the door to get me a tank Interview continued as the resident began to cry. Further interview revealed "she [CSC] yelled at me and told me ! wasn't supposed to have 2 oxygen tanks! was so upset! couldn't sleep all night" Interview with the Activities Assistant (AA) on 1/3/1/7 at 12:25 PM, in the conference room, revealed the AA was working on "bulletin boards" and observed Resident #139"ais she came around the corner to the 600 Half." Interview continued, "[Resident #139] came up to me crying on Friday [1/27/17] and explained to me what happened. I told her to report it immediately to [Staff Development Coordinator (RN #3)] and [Assistant Director of Nurses]. [Resident #139] said she ran out of oxygen and [CNA #4] went out the dining room door to go get her some[CSC] asked "Wy do you need 2 oxygen [tanks]?" [Resident #139] comes to a lot of activities and she normally is not upset and I knew she was really upset that day [1/27/17]." Interviews will continue until substantial compliance is achieved as determined by QAPI. AD HOC QAPI meeting was held on 1/30/17 to review facility plan of correction for concern identified which included Administrator, DON designee, Medical Director and 3 Department Leadership members. To validate compliance, results of staff and resident interviews will be reviewed during QAPI meetings with revisions to the plan as deemed appropriate by the QAPI Committee.	JEFFERS	SON CITY HEALTH A			2	83 W BROADWAY BLVD		
she wouldn't, then [CNA#4] went out the door to get me a tank" Interview continued as the resident began to cry. Further interview revealed "she [CSC] yelled at me and told me I wasn't supposed to have 2 oxygen tanksI was so upsetI couldn't sleep all night" Interview with the Activities Assistant (AA) on 1/31/17 at 12:25 PM, in the conference room, revealed the AA was working on "bulletin boards" and observed Resident #139"as she came around the corner to the 600 Half." Interview continued, "[Resident #139] came up to me crying on Friday [1/27/17] and explained to me what happened. I told her to report it immediately to [Staff Development Coordinator (RN #3)] and [Assistant Director of Nurses]. [Resident #139] said she ran out of oxygen and [CNA#4] went out the dining room door to go get her some[CSC] asked 'Why do you need 2 oxygen [tanks]?' [Resident #139] comes to a lot of activities and she normally is not upset and I knew she was really upset that day [1/27/17]." Interview with CNA#4 on 1/31/17 at 12:35 PM, in the conference room, confirmed Resident #139	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	'IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
1/27/17, and reported her oxygen tanks were empty. Continued interview confirmed the CSC was yelling at Resident #139, "was very loudsounded like a pissed off mother scolding her childthe lady [Resident #139] was crying and was tore upeverybody in there heard itthe lady [Resident #139] kept telling her she couldn't breathe[CSC] yelled what are you doing with 8 liters of oxygen" Interview with the Assistant Director of Nurses (ADON) on 1/31/17 at 2:17 PM, in the conference		she wouldn't, then [get me a tank" Interested to began to c "she [CSC] yelled supposed to have 2 upset! couldn't sle Interview with the At 1/31/17 at 12:25 PA revealed the AA was and observed Resid around the corner to continued, "[Reside on Friday [1/27/17] shappened. I told he [Staff Development [Assistant Director of said she ran out of of the dining room dood asked "Why do you [Resident #139] conshe normally is not really upset that day Interview with CNA; the conference room was in the dining room 1/27/17, and reported empty. Continued in was yelling at Resid loudsounded like a her childthe lady [I and was fore upev lady [Resident #139] breathe[CSC] yelled liters of oxygen"	CNA #4] went out the door to rerview continued as the ry. Further interview revealed at me and told me I wasn't coxygen tanksI was so see all night" ctivities Assistant (AA) on M, in the conference room, see working on "bulletin boards" dent #139 "as she came to the 600 Half." Interview and explained to me what the roreport it immediately to Coordinator (RN #3)] and of Nurses]. [Resident #139] exygen and [CNA #4] went out or to go get her some[CSC] need 2 oxygen [tanks]?" hes to a lot of activities and upset and i knew she was a [1/27/17]." #4 on 1/31/17 at 12:35 PM, in an confirmed Resident #139 om before lunch service on the dher oxygen tanks were need the coxygen tanks were need to coxygen tanks were need the coxygen tanks were need to coxygen tanks t	F	223	Interviews will continue until substantial compliance is achieved determined by QAPI. AD HOC QAPI meeting was heled 1/30/17 to review facility plan of correction for concern identified included Administrator, DON designee, Medical Director and Department Leadership member To validate compliance, results staff and resident interviews will reviewed during QAPI meeting revisions to the plan as deeme	ved as Id on which 3 rs. I of II be s with d	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: CWUS11

Facility ID: TN4501

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12:04:48 p.m.

8/30

03-09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA), 0938-0391 TE SURVEY MPLETED
Į.			445246	B. WING	š			
L		PROVIDER OR SUPPLIER SON CITY HEALTH AN		•	21	TREET ADDRESS, CITY, STATE, ZIP CODE 83 W BROADWAY BLVD EFFERSON CITY, TN 37760	<u> </u>	<u>//31/2017</u>
L	(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	n oc	(X5) COMPLETION DATE
	F 225 SS=G	room, revealed the process of Development Coord going on after RN # Continued Interview "overheard [Resid DON] and [RN #3] a manner [CSC] did actions against [CSC] the ADON confirmed was upset and did not interview with RN #3 the conference room summoned by the Aland CNA #4 about the conference room summoned by the Aland CNA #4 about the conference room side [CSC] has no rightly the process of the proc	ADON asked the Staff linator (RN #3) what was 3 had spoke to [CSC]. revealed the ADON, ent #139] reporting to [the about being talked to in the aware several disciplinary C]." Interview continued and a she was aware the resident of check on her. 3 on 1/31/17 at 2:28 PM, in a revealed RN #3 had been A to talk with Resident #139 he incident in the dining room with RN #3 confirmed wisibly upset during the terview revealed, "[CNA #4] ght to talk to [Resident #139] erview revealed RN #3 then I had mouthed somebody." 2N on 1/31/17 at 4:23 PM, in revealed facility employees erbal abuse on 1/27/17 during are also and a surface of the contains and a surface of the	F 23	223			
)ľ	RM CMC.254	7/02 00) [[_ L		I	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CWUS11

Facility ID: TN4501

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9/30

12:05:17 p.m. 03--09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRIN	TED:	02/13	3/2017
F	DRM /	APPR	OVED
OMB	NO.	0938	.0391

STATEMENT	TOP DEPLY TO AIRL	W WEDICAID SERVICES				MR NIC	0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIP	LE CONSTRUCTION	(X3) DA1	r. 0936-039 TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER		D. 171143			01/	/31/2017
					STREET ADDRESS, CITY, STATE, ZIP CODE		
JEFFER.	SON CITY HEALTH AN	ND REHAB CENTER			283 W BROADWAY BLVD		
		·			JEFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) F225	BC.	(X5) COMPLETION DATE
F 225	Continued From page				Penidant 120 upo intensiound bu		2/06/17
	P		F2		Social Worker on 1/29/17. She		2,00711
	(II) Have had a findi	ng entered into the State	Ì		remains at her baseline for facility		
	nuise alde registry d	concerning abuse, neglect,					
	misappropriation of	atment of residents or			milleu involvement, psychosocial	and	
	misappropriation of	utell property; or			emotional well-being.		
	body as a result of a exploitation, mistrea	ary action in effect against his license by a state licensure finding of abuse, neglect, atment of residents or			Aide identified no longer works for facility as of 2/1/17.	i	
	misappropriation of	resident property.			Preliminary report of event report	ea to	
	(4) Damasta II. or			i	state agency on 1/30/17 with fina		_
j	(4) Report to the Sta	ate nurse aide registry or			report submitted to state agency:	2/3/17	
	actions by a court of	any knowledge it has of law against an employee,			by the director of nursing.		
	nurse aide or other f	Unfitness for service ac a			Current residents who can partici	pate	
				- }	in interviews were interviewed by		
	(c) in response to all	legations of abuse, neglect,		Ì	social services on 2/2/17 to deter	mine	
1	exploitation, or mistr	eatment, the facility must:			if they had been spoken to in a	}	·
		• '			disrespectful way.		
]	(1) Elistre that all al	leged violations involving		İ			·
ĺ	including injuries of	oitation or mistreatment,			Staff were interviewed by staff	ĺ	
	including injuries of a	Inknown source and		Į	development coordinator to deter		
	reported immediately	resident property, are y, but not later than 2 hours			if they had knowledge of disrespe	ctful	,
	after the allegation is	made, if the events that		ĺ	treatment/verbalizations in the	- {	i
	cause the allegation	involve abuse or result in			presence of residents. These		
	serious bodily injury.	or not later than 24 hours if		ĺ	interviews were completed by 2/3	/17.	l
1	the events that causi	e the allegation do not involve l			•	İ	
	abuse and do not res	Sult in serious bodily injury to t			Facility reviewed records for any		
	trie administrator of t	he facility and to other			allegations of abuse for the past 3		İ
	omciais (including to	the State Survey Agency and I			days and none were identified.		
	auuli protective servi	Ces where state law provides I		- }			. 1
Į.	յու յույթաննինը յդ (ՕՈՇ	1-term care facilities) in				1	
	accordance with Stat	te law through established					1
ļ	procedures.			ļ		J	
	(2) Have evidence th	at all alleged violations are		Ī			

STATEMEN AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	U938-U391 E SURVEY
		·	A. BUILD	ING.		COM	PLETED
NAMEOR	BROUNDER OR GUIDRI (Ch.	445246	B. WING	_		01/	31/2017
	PROVIDER OR SUPPLIER SON CITY HEALTH AN	ND REHAB CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 83 W BROADWAY BLVD EFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	thoroughly investigation (3) Prevent further rexploitation, or mist investigation is in proceeding the result administrator or his representative and the with State law, inclu Agency, within 5 wo if the alleged violation corrective action mutation. This REQUIREMENT by: Based on facility poemployee education review, review of a finterview, the facility investigating and reviewed for abuse the facility investigating and reviewed for abuse of the facility facility Management. When an alleged is reported, the facility Facility Management in When an alleged is reported, the facility facility investigating includes the facility facility. We state of policythe State lice responsible for survefacility Verbal abus oral, written, or gestincludes disparaging	potential abuse, neglect, reatment while the ogress. Its of all investigations to the or her designated to other officials in accordance ding to the State Survey rking days of the incident, and on is verified appropriate ast be taken. It is not met as evidenced elicy review, review of a materials, medical record facility investigation, and a falled to follow policy for porting an allegation of abuse (#139) of 4 residents of 32 residents reviewed. It is not met as evidenced elicy investigation, and a falled to follow policy for porting an allegation of abuse (#139) of 4 residents of 32 residents reviewed. It is not met as evidenced elicy for policy investigation, and a falled to follow policy for porting an allegation of abuse (#139) of 4 residents of 32 residents reviewed. It is not met as evidenced elicy for policy investigation, and a falled to follow policy for porting an allegation of abuse (#139) of 4 residents elicy for evidents reviewed. It is not met as evidenced elicy for policy for policy for policy for policy for policy for policy investigation, and a falled to follow policy for policy investigation a falled to follow policy for policy investigation and policy investigation and policy investigation and policy investigation and policy investigation and policy investigation and policy investigation and policy for policy investigation and policy for policy investigation and policy for policy investigation and policy for policy investigation and policy for policy investigation and policy for	F 2	225	The policy for reporting resident abuse was reviewed by the Administrator on 2/1/17 and dee to be appropriate. Education began on 2/1/17. Regional Clinical Coordinator provided training to administrate director of nursing on 2/1/17. Administrator re-educated all leadership staff in relation to abuprohibition and reporting abuse including definitions, reporting requirements, and provision of measures to ensure safety and protection of the resident(s). This completed by 2/3/17. Mandatory in-service education scheduled for facility staff across departments for abuse prohibition reporting abuse including definition reporting requirements, and provious safety and protection of reside PRN staff and staff on leave will receive education prior to working This education was provided with face-to-face opportunity to ask questions and validate understated facility policies and regulatory requirements. This education was completed by 2/06/17. A Resident Council meeting was by 2/6/17 to review abuse prohibitions.	med r and use s was all n and ons, vision ent(s). nding s	



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/13/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
I SIVIEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	Tipi	LE CONSTRUCTION	MB NO	. 0938-0391
	- VOINCOTION	IDENTIFICATION NUMBER:	A. BUILD	ing	EE CONSTRUCTION		E SURVEY
					<u> </u>	00,1	W CEICU
NAME OF	PROVIDER OR SUPPLIER	445246	B. WING	_		04/	31/2017
					TREET ADDRESS, CITY, STATE, ZIP CODE	1	J 1120 11
JEFFER	SON CITY HEALTH AN	ND REHAB CENTER			83 W BROADWAY BLVD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			EFFERSON CITY, TN 37760		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DE	(X5) COMPLETION DATE
F 225	observing an incider immediately reports. Administrator or Dirimmediate investigated Review of an emploe "Reporting Abuse", if for the Protection of involved staff members admitted to the diagnoses including Failure with Trached Failure, and Chronic Disease. Review of a facility if documented by the related to an allegative related to an allegative related to an allegative feel bad thanks & I was just with tanks n, harassmentAny individual nt of resident abusemust such incident to the ector of Nursing An	F 2	25	and discuss need for residents to immediately report inappropriate conversation or any action that reindicate a resident is being abus. To validate compliance, the staff development coordinator and so worker will interview five staff members and five residents wee for four weeks. Non-interviewable residents will be observed by nurduring medication administration routine nursing care for changes may indicate abuse. If no issues identified the facility will interview staff member and one resident weeks to ensure unreposabuse has not occurred and that members can demonstrate knowledge and understanding of policies and procedures of the facility evices will continue until substantial compliance is achieved determined by QAP!. AD HOC QAPI meeting held to refacility plan of correction for concidentified which included Administrator, DON designee, McDirector and 3 Department Leader members. This meeting was held 1/30/17. To validate compliance, results of staff and resident interviewill be reviewed during QAPI meetings with revisions to the planetings ith revisions to the planeting with revisions to th	night ed. f cial ekly e rses and that are vone veckly orted staff f the cility. ed as eview edical ership d on views		

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DA7	<u>. 0938-0391</u> FE SURVEY MPLETED
		445246	B. WING				
1	PROVIDER OR SUPPLIER SON CITY HEALTH AN	ND REHAB CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760	<u>l 01</u>	<u>/31/2017</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D RE	(X5) COMPLETION DATE
·	with [the Director of my shift, probably be interview with Resid PM, in her room, remain dining room for when she, "ran our oxygenasked for replaced, but [CSC] away3 times I ask she wouldn't, then [Gget me a tank" Interesident began to crevealed "she [CS wasn't supposed to so upset! couldn't interview revealed the conference room was in the dining room that the conference room was in the dining room that through the dinretrieve full oxygen to confirmed the CSC and "was very loud mother scolding her #139] was crying and there heard itthe latelling her she could what are you doing with the Dothe conference room had witnessed the velunchtime, the investigations in the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime, the investigation of the conference room had witnessed the velunchtime.	Nursing (DON)] by the end of y 2:15 PM." Jent #139 on 1/30/17 at 6:00 vealed the resident was in the in lunch on Friday, 1/27/17, at of oxygenhave to have my my oxygen tank to be said she couldn't get it right ed her to get me a fank and CNA #4] went out the door to erview continued as the y. Continued interview CJ yelled at me and told me I have 2 oxygen tanksI was sleep all night" Further he resident had reported the on 1/27/17. H4 on 1/31/17 at 12:35 PM, in a, confirmed Resident #139 om before lunch service on the oxygen tanks were neterview confirmed CNA #4 sing room exterior door to anks. Continued interview was yelling at Resident #139 isounded like a pissed off childthe lady [Resident downstore upeverybody in and the lady [Resident #139] kept in the treathe[CSC] yelled with 8 liters of oxygen" ON on 1/31/17 at 4:23 PM, in a, revealed facility employees erbal abuse on 1/27/17 during tigation of the verbal abuse I 1/29/17, and the accused	F:	225			

12:07:51 p.m. 03-09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES

RS FOR MEDICARE	& MEDICAID SERVICES			FOR	J: 02/13/2017 VIAPPROVED
TOF DEFICIENCIES				OMB NO	<u>0. 093</u> 8-0391
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	TPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
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PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE I	/31/2017
SON CITY HEALTH AN	ID REHAB CENTER		283 W BROADWAY BLVD		
		- 1	JEFFERSON CITY, TN 37760		
I (EACH DEFICIENCY	MUST BE PRECEDED BY FILL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOUID RE	(X5) COMPLETION DATE
Continued From	44			QAPI	
, ==pe;		F 22	5 Committee.		
1/27/17 until 4:22 Pl confirmed the CSC scheduled workday Continued interview follow their policy an reported to the State 483.25(b)(1) TREAT	M. Continued interview was suspended on her next [1/30/17 at 7:30 AM]. revealed the facility failed to d the verbal abuse was not agency until 1/30/17.	F 31	evaluated and re-classified wound nurse/RN on 2/1/17. Physician was notified and obtained on 1/27/17. Resid	by the orders lent	2/09/17
comprehensive asset facility must ensure	essment of a resident, the that-		devices had their skin evalu	lated by	
professional standar pressure ulcers and ulcers unless the incidemonstrates that the demonstrates that the professional standar healing, prevent inferform developing. This REQUIREMEN' by: Based on facility polyreview, interview, and failed to prevent developing the development of the pressure ulcer for 1 in reviewed with medical reviewed.	ds of practice, to prevent does not develop pressure lividual's clinical condition arey were unavoidable; and essure ulcers receives and services, consistent with ds of practice, to promote ction and prevent new ulcers. T is not met as evidenced licy review, medical record d observation, the facility elopment of a stage 2 resident (#40), of 3 residents al devices, of 32 residents.		were reviewed by the DON and deemed to be appropri Facility nurses were re-edu the SDC starting on 2/6/17 was completed by 2/09/17 prevention of pressure ulce medical devices. PRN staff on leave will receive educa working. Audits will be com validate that residents who medical devices have week assessments completed by and that any wounds are cl based on their characteristic Administrative nurses will c	by 1/31/17 ate. cated by and this regarding rs from and staff tion prior to pleted to utilize dly skin nurses assified cs. omplete	
	FROVIDER OR SUPPLIER SON CITY HEALTH AN SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS Continued From page employee was allow 1/27/17 until 4:22 Pl confirmed the CSC scheduled workday Continued interview follow their policy and reported to the State 483.25(b)(1) TREAT PREVENT/HEAL PF (b) Skin Integrity - (1) Pressure ulcers. comprehensive asset facility must ensure standard pressure ulcers and ulcers unless the incidemonstrates that the first of the comprehensive that the composition of the composi	A45246 PROVIDER OR SUPPLIER SON CITY HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 employee was allowed to finish working on 1/27/17 until 4:22 PM. Continued interview confirmed the CSC was suspended on her next scheduled workday [1/30/17 at 7:30 AM]. Continued interview revealed the facility failed to follow their policy and the verbal abuse was not reported to the State agency until 1/30/17. 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, interview, and observation, the facility failed to prevent development of a stage 2 pressure ulcer for 1 resident (#40), of 3 residents reviewed with medical devices, of 32 residents	TOP EFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CATION NUMBER: 445246 B. WING_ PROVIDER OR SUPPLIER SON CITY HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 employee was allowed to finish working on 1/27/17 until 4:22 PM. Continued interview confirmed the CSC was suspended on her next scheduled workday [1/30/17 at 7:30 AM]. Continued interview revealed the facility failed to follow their policy and the verbal abuse was not reported to the State agency until 1/30/17. 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. 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WING STREET ADDRESS, CITY, STATE, ZP CO 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 employee was allowed to finish working on 1/27/17 until 4:22 PM. Continued interview confirmed the CSC was suspended on her next scheduled workday (1/30/17 at 7:30 AM). Continued interview revealed the facility failed to follow their policy and the verbal abuse was not reported to the State agency until 1/30/17. PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. 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(iii) A resident development of a stage 2 prevent infection and prevent new ulcers from developing. (iii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. (iii) A resident receives care, consistent with professional standards of p	TOP DEFICIENCIES PROVIDER ON DETICATION NUMBER 445246 8. WIND REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM BURNERS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 11 employee was allowed to finish working on 1/27/17 until 4:22 PM. Continued interview confirmed the CSC was suspended on her next scheduled workday 1/30/17 at 7:30 AMI). Continued interview revealed the facility failed to follow their policy and the verbal abuse was not reported to the State agency until 1/30/17. 483.25(b)(1) TREATMENT/SVCS TO REVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers and does not develop pressure ulcers and does not develop pressure ulcers and does not develop pressure ulcers and sendands of practice, to prevent pressure ulcers and sendands of practice, to prevent enemals attendands of practice, to promote healing, prevent infection and prevent new ulcers from medical devices. PRN staff and staff on leave will receive education prior to working. Audits will be completed to working. Audits will be completed to working. Audits will be completed to working. Audits will be completed to working. Audits will be completed to validate that residents who utilize medical devices have weekly skin assessments completed by nurses and that any wounds are classified based on their characteristics. Administrative nurses will complete these audits weekly for 4 weeks and then monthly.

12:08:28 p.m. 03-09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/13/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 445246 B. WING 01/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY HEALTH AND REHAB CENTER JEFFERSON CITY, TN 37760 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **ID** PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) Audits will continue until substantial F 314 Continued From page 12 compliance is achieved as determined Review of the facility policy "Prevention of by QAPI. They will be reviewed during Pressure Ulcers", revealed, "...The most common QAPI meetings with revision to the site of a pressure ulcer is where the bone is near plan as deemed appropriate by the the surface of the body...Pressure can also come QAPI Committee. from splints, cast..." Review of the facility's "Clinical Practice Guideline...International NPUAP/EPUAP Pressure Ulcer Classification System" revealed. "...Stage II: Partial Thickness Skin Loss...Partial thickness loss of dermis presenting as a shallow open ulcer..." Resident #40 was admitted to the facility on 12/15/16 with diagnoses including Urinary Tract Infection, Dementia, Atrial Fibrillation, and Osteoporosis with Compression Fractures of the Lumbar Spine, and Vertebral Augmentation Surgery on 12/14/16, Medical record review of the nursing assessment dated 12/15/16 revealed the resident did not have a pressure ulcer on admission. Further review revealed a Norton Plus Pressure Ulcer Scale used for predicting pressure ulcer risk was scored at a "9", with the instruction "score 10 or less = high risk." Medical record review of the care plan dated 12/23/16 revealed the "Focus" problem, "Risk for alteration in skin integrity". Medical record review of a "Continuity of Care"

record dated 12/30/16, revealed the Medical

Medical record review of a physician's telephone

Director wrote "...Back brace when ambulating...Needs to get up to go to the bathroom, wear Back brace when ambulating."

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP		(X1) PROVIDER/SUPPLIER/CLIA	/V25 1411	i Tin	LE GAUGE	OMB NO. 0938-039			
DENTIFICATION MILMORD.		A. BUIL	DING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
NAME OF	PROVIDER OR SUPPLIER	445246	B. WING	=		01	<u>/3</u> 1/2017		
JEFFERSON CITY HEALTH AND REHAB CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 83 W BROADWAY BLVD EFFERSON CITY, TN 37760	<u>, , , , , , , , , , , , , , , , , , , </u>	10 1120 1		
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) RC	(X5) COMPLETION DATE		
	order dated 12/30/1 up in w/c [wheelchai Medical record revie Treatment Record revie telephone orders da Clarification: Back b Medical record revie (MDS) dated 1/12/17 scored a 12 on the E Status (BIMS) indica impairment, and the person for transfers Medical record revie (MDS) dated 1/12/17 scored a 12 on the E Status (BIMS) indica impairment, and the person for transfers Medical record revies skin check dated 1/2 were identified. Medical record revies Care" dated 1/27/17 "Problemabrasion Interview with Regist 1/30/17 at 9:40 AM, a revealed, "[Resider her back from rubbin revealed RN #1 "thou classified it as an abr interview with the Wo 1/30/17 at 2:00 PM, r bbserved on the prev	6 revealed, "Back brace when ir] as tolerated" ew of the December 2016 evealed, "Back brace when chair] as tol [tolerated.]" ew of the physician's ted 1/2/17 revealed, "Order race on when ambulating." ew of the Minimum Data Set 7, revealed the resident had Brief Interview for Mental sting mild cognitive resident required assist of 1 and ambulation. ew of the resident's weekly 17/17 revealed no open areas w of an "Immediate Plan of revealed, "" ered Nurse (RN) #1 on at the nursing station, at #40] has an open area on g against a brace." Interview ight the wound care nurse asion" pund Care Nurse, RN #2, on evealed RN #2 had not its "abrasion" since first flous Friday, 1/27/17.	F	314	,				
	Juservation of Resid	ent #40 on 1/30/17 at 2:30			•	İ	1		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(72) 111	17154	CONSTRUCTION	<u>ЭМВ ИС</u>). 0 <u>938-0391</u>
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI			(X3) DATE SURVEY COMPLETED		
NAMEOF	ROVIDER OR SUPPLIER	445246	B. WING	i		01	/31/2017
JEFFERSON CITY HEALTH AND REHAB CENTER				283	REET ADDRESS, CITY, STATE, ZIP CODE B W BROADWAY BLVD FFERSON CITY, TN 37760	<u>, , , , , , , , , , , , , , , , , , , </u>	13 1/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFIGIENCY)	h af	(X5) COMPLETION DATE
	and there was a prospinal column. The not covered with a cithe most protruding curvature of the spir circular and measure 1.5 cm, with a red riportion of the open aperiwound, red in comments of the comments of the confirmed the size of periwound area. Further with the Astronomic was a stage II pression 1/31/17 at 9:50 All revealed the Certified pathing Resident #40 open area on the resconfirmed the physical properties of the physical properties of th	realed the resident was able ck to the right side of the bed, minent curve of the resident's re was an open area that was fressing and was located on bony prominence of the ne. The open area was red 1.5 cm (centimeters) by m visualized at the bottom area. There was a refor, and measuring 4 cm by 4 con 1/30/17, at 2:30 PM, on in the resident's room, of the open area and the rither interview revealed the re the open area was an sistant Director of Nursing at 3:30 PM, in the refirmed the ADON rea on a bony prominence ure ulcer. ed Practical Nurse (LPN) #2 M, in the conference room, d Nursing Assistants (CNA's) on 1/27/17 reported the ident's back. Interview lian's order written on brace when the resident not the order written by the ntinuity of Care" instructions. realed, "I noticed when she the ton of the brace came the ton of the brace came	F:	314			
RM CMS-2567	(02-99) Previous Versions O	bsolate					i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(V2) LO			OMB NO. 0938-0391		
WAR LEMIN	IND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED			
MANGOO		445246	B. WING	s		` .		
	PROVIDER OR SUPPLIER		·	-	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	31/2017	
	SON CITY HEALTH AI				283 W BROADWAY BLVD JEFFERSON CITY, TN 37760			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	JD		PROVIDER'S PLAN OF CORRECTION	41		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	n DC	(X5) COMPLETION DATE	
F 314	Continued From pa	ge 15	1 ₽⊲	3-1-4	F441		2/09/17	
F 441 SS=D	Interview with the A in the 300 Hall, condeveloped a stage I curvature of her spin came into contact wand confirmed the phrace to be worn in 483.80(a)(1)(2)(4)(e PREVENT SPREAL (a) Infection prevent The facility must estand control program a minimum, the following services understigating, and communicable disease volunteers, visitors, providing services understigational stage conducted according accepted national stage (2) Written standard for the program, while imited to: (i) A system of surver possible communication is presented to the program, while imited to:	DON on 1/31/17 at 4:00 PM, firmed Resident #40 had I pressure ulcer on the bony ne where the back brace where the back brace with the curvature of her spine, by sician had not ordered the the wheelchair. (if) INFECTION CONTROL, D, LINENS Ition and control program. (ablish an infection prevention of (IPCP) that must include, at a wing elements: (venting, identifying, reporting, portrolling infections and asses for all residents, staff, and other individuals upon the facility assessment upon the facility assessment asse 2); (s. policies, and procedures chemist include, but are not illance designed to identify ble diseases or infections and to other persons in the	. ··	314	The 6 residents have received assistance with meals with appropriate hand hygiene. This observed by management staff 1/30/17. Current residents were observe nurses by 2/3/17 to validate appropriate hand hygiene was completed while assisting reside with meals. The hand hygiene policy was reviewed by the director of nurs 1/29/17 and deemed appropriate Mandatory in-service education on 2/06/17 for facility staff regard hand hygiene. This education we completed by 2/09/17. PRN state staff on leave will receive education on leave will receive education on the staff on leave will receive education on leave will receive education while working. Audits will be completed by nursibeginning on 1/30/17 to validate hand hygiene is completed while assisting residents with meals, audits will be completed weekly weeks and then monthly. Audits continue until substantial complete is achieved as deemed by QAP committee. Audit results will be reviewed de QAPI meetings with revision to	on d by ents ing on e. began rding ras ff and ation ses e that e The for 4 s will iance i		
	(il) When and to who communicable disea	m possible incidents of se or infections should be			2/09/17 plan as deemed approp by the QAPI Committee.	oriate		
RM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: CWI IS+1	·					

18 /30

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION MILMPER.		(X2) MU	LTIP		MB NO. 0938-0391		
		IDENTIFICATION NUMBER:	A. BUILI	DING		(X3) DATE SURVEY COMPLETED	
NAME OF		445246	B. WING				l la dina da
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY HEALTH AND REHAB CENTER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 183 W BROADWAY BLVD JEFFERSON CITY, TN 37760	1 07	I/31/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	AE.	(X5) COMPLETION DATE
	(iv) When and how i resident; including be (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employing disease or infected secontact with resident contact will transmit (vi) The hand hygien by staff involved in disease of the facility's IP actions taken by the (A) A system for recounder the facility's IP actions taken by the (b) Linens. Personne process, and transpospread of infection. (f) Annual review. The facility is IP actions taken by the IP actions	ensmission-based precautions event spread of infections; solation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the lible for the resident under the lible for the resident under the estable for the resident under the solation should be the lible for the resident under the lible for the resident under the estable for the facility vees with a communicable skin lesions from direct so or their food, if direct the disease; and e procedures to be followed irect resident contact. Inding incidents identified CP and the corrective facility. In must handle, store, art linens so as to prevent the line facility will conduct an PCP and update their ry. I is not met as evidenced the facility policy, ryiew, the facility failed to	F	141			

19 /30

03-09-2017

DEPAR	TMENT OF HEALTH	AND HU	MAN SERVICES				P	RINTER): 02/13/2017
STATEMEN.	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	(X1) PROV	CAID SERVICES IDER/SUPPLIER/CLIA IFICATION NUMBER:	(X2) MU A. BUILI	LTIF	IPLE CONSTRUCTION	0	(X3) DA	MAPPROVED 0. 0938-0391 TE SURVEY
NAME OF	PROVIDER OR SUPPLIER		445246	B. WING	;	STREET ADDRESS, CITY, STATE, ZIP CO	 DE		/31/2017
JEFFER	SON CITY HEALTH AN	ID REHAE	3 CENTER			283 W BROADWAY BLVD JEFFERSON CITY, TN 37760			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE P	RECEDED BY #1111	ID PREFI TAG	iχ	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOIBG	AE.	(XS) COMPLETION DATE
F 441	the lunch meal serve the findings include Review of the facility	ne betwer ed in the ice. d:	iand Hydiene not	F	141	1			
	assisting a resident with soap and water	lent conta with mea)"	actBefore and after Is (hand washing						
	Observation of Certi #3 on 1/29/17 at 11: service in the dining delivered lunch to the eating utensils and resident while preparing the resident continued observation wheelchair, using bothe 2nd resident their hands. Continued of	10 AM, do room, revenued a top comment of the comme	uring lunch meal vealed CNA#3 dent, touched the alld from her drink, consumption. ed CNA#3 moved a vithout sanitizing the prevealed CNA#2						
	unimapped the residused the utensils to cremoved the lid from Continued observation the 3rd resident to coobservation revealed hands, touched the coopservation the coopservation revealed the coopservation revea	ent's eating the resident the r	ng utensils and sident's food, then lent's cup. ed CNA#3 assisted food. Continued sanifized her						
	door, and delivered to Continued observation unwrapped the utens resident's cup, without continued observation the 5th resident their utensils, and used the food, without sanitizing observation revealed resident to unwrap here.	he 4th research revealed its and put sanitizing the cut to	sident their meal. ed CNA #3 pured milk into the ng the hands. ed CNA #3 served y, unwrapped the t up the resident's nds. Further						

12:11:31 p.m.

20/30

03-09-2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AMD PLAN OF CORRECTION CONTROL DESTINATION NUMBER: A SUILINE CONSTRUCTION A SUILINE CONSTRUCTION CONFIGURATION NUMBER: A SUILINE CONSTRUCTION CONFIGURATION CONFIGURATI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(V2) A01	TIDE		OMB NO. 0938-0391		
JEFFERSON CITY HEALTH AND REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 18 drink into a glass without sanitizing the hands. Interview with CNA#3 on 1/29/17 at 11:23 AM, in the dining room, confirmed CNA#3 had not sanitized her hands between touching contaminated surfaces and delivering and assisting residents with meal set-up. Interview with the Director of Nursing on 1/29/17 at 11:45 AM, in the DON office, confirmed acceptable infection control practice was not performed and the facility's Hand Hydrigap Policy STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760 PROVIDER'S PLAN OF CORRECTION (KS) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 F 441	NAME & CAST	DE CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING.	E CONSTRUCTION	(X3) DA	TE SURVEY	
JEFFERSON CITY HEALTH AND REHAB CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 18 drink into a glass without sanitizing the hands. Interview with CNA #3 on 1/29/17 at 11:23 AM, in the dining room, confirmed CNA #3 had not sanitized her hands between touching contaminated surfaces and delivering and assisting residents with meal set-up. Interview with the Director of Nursing on 1/29/17 at 11:25 AM, in the Don office, confirmed acceptable infection control practice was not performed and the facility's Hand Hydrapa Policy.	NAME OF		445246	B. WING			1		
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RM CMS-2567(02-99) Previous Versions Obsolete		drink into a glass wi Interview with CNA; the dining room, cor sanitized her hands contaminated surfact assisting residents w Interview with the Di at 11:45 AM, in the Di acceptable infection performed and the fa was not followed.	thout sanitizing the hands. #3 on 1/29/17 at 11:23 AM, in infirmed CNA #3 had not between touching ses and delivering and with meal set-up. rector of Nursing on 1/29/17 DON office, confirmed control practice was not acility's Hand Hygiene Policy	F	141				